

**MICHIGAN OTOLARYNGOLOGY
&
FACIAL PLASTIC SURGERY ASSOCIATES**

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

I, the undersigned, acknowledge that Michigan Otolaryngology & Facial Plastic Surgery Associates have made their Notice of Privacy Practices available to me.

(Patient's Signature)

(Date)

(Personal Representative's Signature)

(Date)

(Relationship to patient)

Authorization to release medical information

We understand that medical information about you is personal and we are committed to protecting your privacy. This means that we will not discuss your medical care or financial information with anyone who is not entitled to this information as explained in our notice of privacy practices. However, we also understand that there may be circumstances in which you would expect us to discuss information with someone other than yourself, such as discussing a medical bill with your spouse for a service we perform for you. We would be happy to do this, however, we first need your permission to do so. Therefore, if there is anyone, other than yourself, that you would like to allow us to discuss your protected information with, please list them below.

(Name)

- detailed medical information such as test results
- basic billing information

(Name)

- detailed medical information such as test results
- basic billing information

(Name)

- detailed medical information such as test results
- basic billing information

* To be filed and retained for a minimum of six (6) years.